Supported and Customized Employment Extended Services for Youth Report

Service Start Date: 07/01/2023 **End Date:** _____

Client Name:	VR Specialist:	SE Provider:
Job Title:	Job Start Date:	
Employer:		Supervisor:
Employer Address:		Phone:
Benefits: ☐ Health Insurance ☐ Dental ☐ Paid Vacation ☐ Paid Sick Leave ☐ Retirement Plan ☐ None ☐ Other	Hourly Wage:	Hours per Week:

Attach paycheck stubs or other verification from the employer on employee hours worked.

Hours of on-site job coaching 0.00. Note number of hours each day, to the nearest quarter hour.

07/01/23														

Hours of off-site job support provided 0.00. Note number of hours each day, to the nearest quarter hour.

07/01/23														

Services provided on/off site:	**Comments:**
Liaison support with supervisor and co-workers (for advocacy, communication):	
On-site skill training to learn new job tasks:	
Problem-solving support:	
Transportation support/development of transportation resources as work schedule changes:	
Reporting of income to benefits programs (SSA, DHHS, etc.):	
On-going job coaching:	
Development/ maintenance of natural supports:	
Monitoring worksite accommodations:	
Mental health support:	

Other:	

Employer Report

Performance Measures	**Comments**
Employee strengths:	
Area(s) for improvement:	
Additional comments regarding work performance:	

Client/Authorized Representative Report

Job Satisfaction	**Comments**
Describe the overall level of job satisfaction in the following areas: (work schedule, working conditions, hours, wage, benefits, etc.)	
Describe any area of concern:	
Additional comments:	

I verify that the information above is correct.

Client Signature	Date	Authorized Representative Signature	Date
Specialist Signature	Date	Nebraska VR Specialist Signature	Date

Extended Services Invoice

Client Name:_____

Service Start Date: 07/01/2023 Service End Date: _____

VR Specialist:_____

Provider:_____

Billing Address:_____

Total Hours of Extended Services Provided: 0.00

Total Hours Client Worked: _____

Hourly Rate for Extended Services: _____

(Hours Client Worked x Hourly Rate for Extended Services) Total invoice: $ 0.00

_____

Provider Signature Date